PSG INSTITUTE OF MEDICAL SCIENCES & RESEARCH
PEELAMEDU, COIMBATORE – 641 004

PSYCHOLOGY CASE RECORD SUBMITTED
TO
THE Dr. MGR MEDICAL UNIVERSITY, CHENNAI

IN PARTIAL FULFILMENT OF THE REQUIREMENTS

FOR

THE DIPLOMA IN PSYCHOLOGICAL MEDICINE

EXAMINATION APRIL 2010

CERTIFICATE

This is to certify that this Psychology case record is a bonafide record of work done by **Dr. Shilpa Sri S K** in the Department of Psychiatry, P.S.G. Institute of Medical Sciences & Research, Coimbatore.

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ACKNOWLEDGEMENT

I express my gratitude to **Dr. G. Raghuthaman,** Professor of Psychiatry and Head of the Dept, PSG institute of Medical Sciences & Research, Coimbatore, for allowing me to administer tests to the patients to prepare this case record.

I am very much thankful to **Dr. Anuja S. Panicker,** Assistant Professor in Clinical Psychology, PSG Institute of Medical Sciences & Research for her invaluable assistance, guidance and support in preparation of this record.

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CASE RECORD NO. 1

Name	:	Mr. Gnanaprakash
Age	:	15 years
Sex	:	Male
Educational status	:	9th standard
Occupation	:	Unemployed
Informants	:	Parents
Reliability	:	Fair
Chief Complaints	:	Sad mood, crying spells, suicidal ideas, decreased concentration in studies
Duration	:	1week
Mode of onset	:	Insidious
Precipitating factor	:	Episode was precipitated following Strict warning given by his teacher about studying well for his 10th exams

History of presenting illness :

Patient was apparently normal about a week prior to admission. Informants report that patient is not a good student and used to perform poorly in all his class exams. He was given pass marks by the school authorities in spite poor performance in all the exams. Once patient reached 10^{th} standard, his school teacher apparently warned him that if he did not perform well in the forthcoming class tests, he would not be allowed to sit for his final exams. Following this, patient got very upset and was found to be sitting depressed the whole day and expressed fearfulness. He also had crying spells, decreased concentration in his studies. Patient also expressed suicidal ideas and was found to sleep very less at night.

Periodicity : Continuous

Past history : Nil Significant

Family history : Nil Significant

Socioeconomic Status : Low

Personal History : Patient was born out of a full term normal delivery, milestones reached at appropriate age. There is history of repeated failures from lower classes and being promoted by the school authorities in every class till date.

Premorbid personality : Parents describe him as a sociable and cheerful person. He needs supervision for most of his day to day activities.

Physical Examination : Vitals were stable and Systemic Examination was within normal limits. Patient had low set ears.

Mental State Examination : Patient was well kempt, he made good eye to eye contact and was co operative for examination. Rapport could be easily established. Psychomotor activity was normal. Speech was relevant and coherent, normal reaction time. Depressive prosody was present. His attention and concentration was aroused and sustained. Patient was well oriented to time, place and person. Memory was intact. Thought content revealed worries about future and how he would pass the examination.

Intelligence was found to be below average as he was unable to do simple calculations and also unable to interpret proverbs. He also could not tell the differences and similarities between common objects. There was no abnormality in perception and patient expressed his mood as feeling sad and confused. His affect was found to be dysphoric. Patient did not have any insight into his illness. His fund of knowledge was poor.

With the above history and Mental State Examination, the following Diagnoses were made.

Diagnoses	:	Adjustment disorder
		Below average Intelligence

Aim of Psychological Test

Below average intelligence was suspected, hence IQ testing was carried out.

PSYCHOLOGICAL ASSESSMENT REPORT

Test Administered:

Wechsler Adult Performance intelligence scale - Prabha Ramalingaswamy (WAPIS-PR)

Behavioral Observations**:**

Attention could be aroused and sustained. He was co operative and able to comprehend the test instructions during assessment.

Test findings:

All 5 subtests, namely, Picture completion, Digit Symbol, Block design, Picture arrangement and Object assembly were done.

In Picture completion subtest, patient was able to identify the missing part from the pictures in few items. (Scaled score – 7)

In Digit symbol subtest, he was able to write the appropriate symbols for the digits given. (Scaled score – 8)

In Block design subtest, he was able to reproduce three dimensional figures with blocks as per the stimuli given in easy tasks but was unable to do the difficult items. (Scaled score – 8)

In Picture assembly subtest, patient had difficulty in sequencing the pictures according to the theme of the stories. (Scaled score – 7)

In Object assembly subtest, he was able to join only a few parts of the picture but unable to put all the pieces together correctly. (Scaled score –5)

Overall, patient obtained a scaled score of 35 indicating an Intelligence Quotient (IQ) of 75.

Summary

Patient obtained an IQ score of 75 indicating Border line level of Intellectual functioning.

Suggestions:

1. Feed back to the family regarding his current level of intellectual functioning and the impact on his academics.
2. The boy would benefit from placement in a class with fewer children and one-to-one attention from teacher.

Supervised By

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CASE RECORD NO. 2

Name	:	Mr. Sathik Raja
Age	:	28 years
Sex	:	Male
Educational status	:	10^{th} standard
Occupation	:	Unemployed
Informants	:	Self, Parents
Reliability	:	Fair
Chief complaints	:	Expressing suspiciousness, talking and muttering to self, disturbed sleep, maintaining poor personal care and frequent change of jobs
Duration	:	4 years
Mode of onset	:	Insidious
Precipitating Factors	:	Nil

History of presenting illness : Patient was apparently alright about 4 years back. He reported that his colleagues at his work place have made a plan against him and trying to get him removed from the job. He also reported that his parents are against him and his mother does not take care of him properly. He accuses his mother of giving affection only for his elder brother and because of which he is in a very good position and become a lawyer. Patient

also expressed suspiciousness that people in the neighboring streets talk about him and discuss about him. Parents report that patient would apparently pick up fights with a lot of people for this reason. He would be found smiling and muttering to himself at various times and would not have any explanation for the same. Parents also report that, patient would not take bath regularly, refuse to comb his hair, change clothes and had very poor personal hygiene. He has repeatedly changed jobs and has not held a single job for more than a month. Many times the patient was terminated from the job as he was not found to be efficient. He complained of disturbed sleep and parents reported that he would roam around in the night aimlessly.

Periodicity	:	Continuous
Past History	:	Nil
Family History	:	No family history of mental illness
Socioeconomic status	:	Middle
Personal history	:	Patient was born out of a full term

normal delivery and milestones attained at appropriate age. He has completed 10^{th} standard. Patient was working as a salesman. He has changed around 15 to 20 jobs till date.

Premorbid personality : Parents report that prior to the onset of illness, patient was a sociable, cheerful and easy going type of individual and did not have any history of substance abuse.

Physical examination : Vitals were stable and Systemic Examination was within normal limits.

Mental state examination : Patient was well kempt and alert. He made eye to eye contact and was co operative. Rapport was difficult to establish. He was over familiar with therapist. Psychomotor activity was increased. His speech was relevant and coherent and reaction time was decreased. Volume and tone of speech was increased. His attention was aroused but not sustained. Patient was oriented to time, place and person. His immediate, recent and remote memory was intact. In thought process, patient had tangentiality in the form of thought, stream of thought was increased, content revealed delusions of reference and persecution. Patient was unable to interpret any of the given proverbs and could not explain the differences and similarities between common objects. He denied having any hallucinations. Patient expressed his mood as fearful but had restricted affect. He did not have any insight in to his illness. Test judgment was impaired. His fund of

knowledge was average.

With the above history and mental state examination, the following differential diagnoses were made

Differential Diagnoses : Schizophrenia

Mania with psychotic symptoms

Aim of psychological testing : Patient had some affective symptoms, Psychological testing was done to rule out possibility of mood disorder.

PSYCHOLOGICAL ASSESSMENT REPORT

Purpose of assessment: Diagnostic clarification

Test Administered : 1. Thematic Apperception Test (TAT)

2. Rorschach inkblot test (Rorschach)

Behavioral observations

Attention could be aroused and sustained. Patient was repeatedly asking about the purpose of assessment. Initially he was restless and rapport was difficult to establish as patient was suspicious of the therapist.

Test findings

Intellectual factors in functioning

Assessment indicated that patient had moderate level of intellectual efficiency (Structure and content - TAT, W responses - Rorschach)

Diagnostic indicators

Overall assessment indicates the presence of reduced ties with reality and formal thought disorder (F^- responses and ↓D % - Rorschach) Presence of illogical content, disconnection in stories and irrelevant themes on TAT also confirmed the same. Neologisms were prominent in all of the TAT stories.

Interpersonal relations

Testing is indicative of difficulties in interpersonal sphere, possibly due to difficulty in placing trust in others and decreased empathy (↓M –

Rorschach) in the familial sphere, difficulty in areas of relationship with father and mother indicated. (Violent themes, past relationship issues with parents in TAT content)

Summary

Overall, testing showed the presence of formal thought disorder, possibly Schizophrenia.

Suggestions

1. Feedback to the family members on test findings and the role of psychopathology in influencing his current maladaptive functioning.
2. Suggestions for vocational rehabilitation can be discussed with patient and family.

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CASE RECORD NO. 3

Name	:	Ms. Shalini
Age	:	24 years
Sex	:	Female
Educational status	:	M.Com
Occupation	:	Housewife
Informants	:	Patient, family members
Reliability	:	Fair
Chief complaints	:	Back pain, Recurrent episodes of unresponsiveness with swirling movements of the whole body, disturbed sleep.
Duration	:	9 months
Mode of onset	:	Insidious
Precipitating factors	:	Following her marriage

History of presenting illness : Patient apparently got married about 9 months back. On the same day, she started complaining of having back pain which was of severe nature and lasting few minutes to 2 hours. She consulted many neurologists and orthopaedicians for the same. All the investigations were done and found to be normal. She was prescribed medications but she did not report any improvement in her back pain with them. Patient also had

sleep disturbance for a week before coming to psychiatry OPD. She had told her family that she does to wish to live as she was unable to tolerate the pain. She was eating very little as she complained that intake of food worsened her pain. Two days before presentation to OPD, patient started having episodes of unresponsiveness for a few minutes. These episodes used to be accompanied by swirling movements of the body and patient was found lifting both her lower limbs. She reported complete amnesia for the episode. After 15 to 20 minutes patient used to become completely alright and no confusion was noticed.

Periodicity : Episodic

Past History : Patient had similar episodes of unresponsiveness and swirling movements of the body in the past. She also had symptoms suggestive of possession attacks (patient would be found talking as if she was 'lord nagaraja' and predict something about future). She was treated by various psychiatrists for the above symptoms in the past.

Family history : No history of mental illness in family

Socioeconomic status : Upper middle class

Personal history : She was born out of a Full term normal delivery, milestones were normal. Patient had finished her M.Com.

Marital History : She is married for 9 months and there is no history of any marital conflicts.

Physical examination : Her vitals was stable and systemic examination was within normal limits.

Mental State examination : Patient was not groomed well. She was unresponsive initially and was making abnormal movements of her whole body. She lifted both her lower limbs, after a while she became normal. Psychomotor activity was normal. Her speech was decreased, relevant and coherent, reaction time was increased. She was oriented to time place and person. Memory was intact. She expressed concerns over her back pain and hoped that she would become better. There was no abnormality in perception. She reported to have a depressed mood but had a reactive affect. Social judgement was impaired. Her insight was grade 3.

With the above history and mental state examination, the following diagnoses were made.

Diagnoses	:	Dissociative motor disorder Somatoform disorder
Aim of psychological testing	:	To elicit possible stressors.

PSYCHOLOGICAL ASSESSMENT REPORT

Purpose of assessment: To elicit Stressors

Tests Administered : 1.16 Personality Factor test (16 PF)

2. Sentence completion test (SCT)

3. Thematic Apperception Test (TAT)

Behavioral Observations

Patient was co operative for assessment. Her attention was aroused and sustained. Rapport could be easily established.

Test Findings

Intellectual factors in functioning

Assessment is indicative of average intellectual functioning (Intelligence Factor-Factor B in 16 PF, Structure and content – TAT stories)

Emotional factors in functioning

Responses in TAT stories indicated the presence of several unresolved conflicts(related to financial concerns, unknown fears) which the patient has difficulty in acknowledging and expressing) Tendency to be worried and apprehensive with underlying depressive features were indicated (depressive themes – TAT content; Factor O – 16 PF) Patient appears to have significant guilt feelings, possibly about her past mistakes, associated with need for punishment and expressing the need to be forgiven (TAT content) Patient also

showed a tendency to be manipulative as indicated by the high Lie score in 16 PF (Factor MD)

Diagnostic indicators

Assessment is indicative of presence of depressive features with underlying stressors (TAT and SCT content) which the patient failed to express. These are indicative of poor coping skills.

Interpersonal factors in functioning

Patient appears to have satisfactory Interpersonal relationships with husband and siblings. Indications of possible conflicts with mother were present (Fear and minimal communication with the mother - SCT & TAT content)

Summary

Assessment is indicative of significant stressors in the form of unresolved conflicts. Affective symptoms are also present. Current dissociative symptoms can be possibly attributed to poor coping skills.

Suggestions

1. Feedback to patient and family regarding the current psychopathology and its role in her current difficulties
2. Encourage patient to ventilate regarding her difficulties
3. Supportive psychotherapy.

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CASE RECORD NO. 4

Name	:	Ms. Jyothi lakshmi
Age	:	38 years
Sex	:	Female
Educational status	:	Illiterate
Occupation	:	Daily wager in a mill
Informants	:	Patient and her husband
Reliability	:	Fair
Chief Complaints	:	Poor communication with family members, decreased sleep and appetite feeling sad, sitting in the same place for long periods of time
Duration	:	6 days
Mode of Onset	:	Acute
Precipitating factors	:	Following joining work for first time

History of presenting illness : Patient was apparently normal about 5 days prior to admission. Her husband had been insisting that she should join for work, so she joined as a daily wager in a nearby mill. Following that, patient was found to have disturbed sleep. She was appearing sad all the time, not taking any interest in her daily routine work. She complained of feeling

tired even on doing minimal work. Patient was not taking care of her children as before. She used to be preoccupied in her own thoughts and would be found sitting in the same place for long periods of time. She complained of hearing nonexistent voices which were commenting about her continuously. She expressed wishes to die on several occasions. Initially, patient was having less communication with family members but within two days she became completely mute, stopped eating food, after which she was brought to the hospital.

Past History : Patient was admitted in the past for similar symptoms and diagnosed for depressive disorder with catatonia. She improved with antidepressants and antipsychotic medications and remained asymptomatic for a year

Family history : History of mental illness in elder brother, on psychiatric treatment.

Socioeconomic status : Low

Personal History : Illiterate, currently not working

Premorbid personality : Patient is described as an Extrovert, hardworking, cheerful and religious individual.

Physical examination : Vitals were stable and Systemic examination was within normal limits

Mental State Examination : Patient was not groomed well. She did not make any eye to eye contact and was looking towards the floor. Rapport was difficult to establish. Patient was not co-operative for examination. Her speech output was reduced, reaction time was increased, and tone and volume was decreased. She had psychomotor retardation and mild ambitendency was present. Subsequent MSEs showed intact higher mental functions. She expressed ideas of hopelessness and suicidal ideas. She had 3rd person auditory hallucinations. She expressed sad mood and her affect was dysphoric. Her personal judgment was impaired.

With the above history and Mental state examination, a diagnosis of Severe depression with psychotic symptoms was made. Since patient showed rapid improvement in her symptoms in hospital stay, possibility of Dissociative disorder was considered.

Differential Diagnoses

- Recurrent depressive disorder – current episode Severe Depression with Psychotic symptoms
- Dissociative Disorder

PSYCHOLOGICAL ASSESSMENT REPORT

Aim of psychological testing : Diagnostic Clarification

Test administered: Thematic Apperception Test (TAT)

Behavioral observations

Attention was aroused and sustained. Rapport could be easily established. Patient was crying during assessment and repeatedly asking if she was doing the tests in a right way. She took a long time to respond to test stimuli.

Test findings

In TAT, Patient was asked to write stories based on her perception of the themes shown in the picture cards.

The patient was noticed to identify with people and the situations depicted in the cards. In her responses, she thought she has committed a mistake and is being questioned about her actions. These responses were indicative of sense of self doubt, guilt and need for punishment (abasement).

Her responses were also centered on marital conflicts and a sense of not being given a chance to express herself. This indicates a press of dominance resulting in a need for nurturance and acceptance in the interpersonal relationship in family related areas.

In reaction to one of the pictures showing a water body, the patient identified the sorrow in her life with the scene by comparing this water body to the water from tears in her eyes. Need for nurturance and acceptance were present.

This indicated predominantly sad themes, sense of hopelessness and helplessness regarding future.

Summary

Overall, Testing is indicative of presence of Depressive features.

Suggestions

1. Feedback to the family members on test findings and the role of her psychopathology in influencing her current maladaptive functioning.
2. Allowing patient to ventilate regarding her difficulties and counseling regarding the same

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CASE RECORD NO. 5

Name	:	Mr. Shanmuga Sundaram
Age	:	42 years
Sex	:	Male
Educational Status	:	9th standard
Occupation	:	Security guard
Informant	:	Patient's wife and mother
Reliability	:	Adequate
Chief complaints	:	Irrelevant talk, sleep disturbance, inability to recognise family members and friends
Duration	:	4 months
Mode of onset	:	Insidious
Precipitating factors	:	Nil

History of presenting illness : Patient was apparently normal until 4 months back, following which, his family members noticed him to be repeating the same sentences many times. He had significant sleep disturbance and for the last two months, he stopped going for work. Family members report that many times he has failed to recognise his close friends and family members and has landed up calling them by some other name. On few occasions, he apparently forgot the way to his house and lost his way. He went

on some other unfamiliar road and was brought back home by the family members. He talks irrelevantly at times saying that he is in his office when actually he would be elsewhere. At times he would apparently just sit in the same place and stare at the ground for long periods of time. Patient had to be repeatedly instructed by the family members to do his routine activities. He would ask for breakfast twice saying that he had not had it, when in fact, the family would have given the same some few minutes earlier. His sleep was found to be disturbed.

Past History	:	Nil
Family History	:	Nil
Socioeconomic status	:	Middle
Personal History	:	History of Poor academic performance was present.
Premorbid personality	:	Introvert
Physical examination	:	Vitals were stable and Systemic examination was within normal limits.

Mental state examination : Patient was unkempt and making eye contact briefly. Rapport could not be established. He was very restless during examination, trying to pick up files on the table and walking around in the interview room. He had spontaneous and irrelevant speech. Patient's attention was aroused but ill sustained. He was disoriented to time, place and person. His immediate and recent memory testing showed impairment. Remote memory was preserved and confabulation was present. Abstract thinking was impaired. Patient expressed to be having cheerful mood and affect was reactive. He did not have any insight in to his illness (grade 1)

MMSE : 12/28.

Diagnosis : Dementia

Aim of Psychological Testing : To look for particular lobe involvement.

NEUROPSYCHOLOGICAL ASSESSMENT RECORD

Test administered: NIMHANS Neuropsychological Battery

Handedness: Right

Time Taken: 2 hours

Test findings

Frontal lobe

For the assessment of frontal lobe functions, attention, scanning, ideational fluency, abstraction, kinetic melody and delayed recall were assessed. Attention was assessed using number cancellation task. In this task, patient was able to attempt only the 1st twenty items of which significant errors were made. In scanning test, patient was distractible and unable to strike out the numbers in correct numerical order. In the ideational fluency test, he was correctly able to name the objects made out of wood as well as round objects. Similarities and differences between objects and proverb test were asked for abstraction test. He was able to say differences but unable to say similarities. Out of the proverbs given, patient was unable to explain any of them given. Tapping test was used for assessing kinetic melody, in which, he was unable to reproduce the hand movements of the examiner. In delayed

response learning, patient was unable to perform any of the mental arithmetic tasks.

Ideational fluency was intact. Attention could not be aroused. Patient was distractible. He had moderate impairment in abstraction. Severe impairment was seen on delayed recall and kinetic melody. Total impairment was seen in scanning.

Parietal lobe

For the parietal lobe function, visuo spatial perception, visuo spatial construction and parietal focal signs were assessed.

For assessing visuo spatial perception, Bender Gestalt test was used. In this task, he was unable to copy the two dimensional figures shown to him. For assessing visuo spatial construction, block design and object assembly task were used. In the block design test, he was unable to make three dimensional reconstructions with blocks of the two dimensional pictures shown. In the object assembly test, he was unable to join any of the pieces to make whole figures, in any of the test items. In the test for agnosias, visual agnosia(naming objects), colour agnosia(naming colours shown and colour of objects), finger agnosia(naming the correct hand and finger shown by examiner), tactile agnosia(identifying objects with eyes closed) and spatial agnosia(copying figures shown) were assessed and apart from colour agnosia, he was unable to

perform in any of the subtests. Test for apraxia included ideomotor and ideational apraxia. He was able to perform adequately in two items of this test.

Severe impairment was seen in visuo spatial perception and visio spatial construction. Parietal focal signs in the form of agnosias (object, picture, colour, finger and tactile) were prominently evidenced during assessment. Apraxias (ideational and ideomotor) were present.

Temporal lobe

Left

Left temporal lobe function was assessed using verbal comprehension, sentence repetition and verbal learning and memory tasks. He was able to correctly answer to all the questions asked in the verbal comprehension task. For sentence repetition, he was able to recall short sentences; however, he was unable to recall longer sentences. Confabulation was also noted. In verbal learning and memory, he was unable to recall any of the phrases of the story given over multiple trials. In this task also, confabulation was noted.

Ability for verbal comprehension was intact. Moderate impairment was present in sentence repetition. Severe impairment was seen on verbal learning and memory.

Right

Benton visuo retention test was used for assessing visual integration and visual memory. He was able to correctly recall and reproduce some of the figures shown.

Minimal impairment was present in visual integration and visual memory.

Impression

The Neuropsychological profile is indicative of Global impairment.

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